Treatment Plan (Form)
(Confidential)

State of California **Treatment Plan** VCGCB-VOC-6015 *(Revised 09-25-08)*	**California Victim Compensation and Government Claims Board (www.vcgcb.ca.gov)**

Only if requested, return form to: **Victim Compensation Program** **P.O. Box 942003** **Sacramento, CA 94204-2003** Or Fax to: 1-866-966-8669, or send to your local Victim/Witness Assistance Center Verification Unit	Application Number:	Date Form Sent:
	Victim's Name:	
	Claimant's Name:	
	Incident Date:	

In order for the Victim Compensation Program to pay for services, the client's application must be found eligible. After eligibility has been determined, the Victim Compensation Program may consider reimbursement for outpatient mental health treatment up to the client's session limit, as shown in the chart below. As a condition for reimbursement, this Treatment Plan is to be completed in its entirety by the end of the 5th session provided and retained in your client files. You may use additional pages if necessary.

Statute requires that the Victim Compensation Program verify that treatment is necessary as a direct result of the crime for which the application was filed. Therefore, the Treatment Plan must be made available to the Victim Compensation Program upon request. (*Additional information, which may include session notes, may be needed to verify the appropriateness of reimbursement*.) Failure to complete this form may result in a denial of further payment or a repayment for services previously reimbursed.

Please be advised that treatment provided to the client by another mental health provider may have been deducted from the amount of sessions available under his or her initial session limit.

Reimbursement beyond a client's session limits requires the treating therapist to complete and submit an Additional Treatment Plan. **Additional payments will not be authorized for sessions beyond the client's limit until a completed Additional Treatment Plan has been submitted to and approved by the Program.**

Mental Health Benefit Service Limitations
(For applications received on/after 01-24-06)

Service Limitation	Client/Patient
40 Session Hours	Direct Victim
30 Session Hours	*Direct Victim of Unlawful Sexual Intercourse *(Penal Code, section 261.5(d))* Derivative Victim who is a surviving parent, sibling, child, spouse, registered domestic partner, or **fiancé (fiancée) of a victim who becomes deceased as a result of the crime *Derivative Victim who was a minor at the time of the crime Derivative Victim who was one of two primary caretakers of a direct victim who was a minor at the time of the crime **** Not to exceed the statutory $3,000 outpatient mental health limit for applications received prior to 01-01-08*** ***** Must have witnessed the crime***
15 Session Hours	*Derivative Adult Victim * A derivative victim who does not meet any of the benefit limits listed above

Session Calculations (Individual/Family Therapy)

½ Session =	Less than 45 Minutes
1 Session =	45 to 74 minutes

1 ½ Session =	75 to 104 minutes
2 Sessions =	105 to 120 minutes

Group Therapy = One group mental health counseling session is the equivalent of one-half of an individual mental health counseling session of the same length.

As required by law, the information requested must be returned to the Victim Compensation Program within ten (10) business days and must be provided at no cost to the client, the Victim Compensation Program, or local Victim/Witness Assistance Centers. The Victim Compensation Program certifies that there is a signed authorization on file for the release of the information requested.

Please complete all questions unless otherwise specified.

1. Name of Client:

2. Name of Victim:

3. Client's Relationship to Victim:

4. Name of Therapist: Provider Organization Name (if applicable):

5. License/Registration Number and Expiration Date:

6. Mark Appropriate Box for Title of Licensed/Registered Therapist:

☐ LMFT ☐ Registered Psychologist ☐ LMFT Intern
☐ LCSW ☐ Resident in Psychiatry ☐ ASW
☐ Licensed Clinical Psychologist ☐ Registered Psychological Assistant ☐ Other (Please specify):
☐ Psychiatrist

7. Name and Title of Supervising Therapist (If applicable):
License Number: Expiration Date:

8a. What type of crime is the client being treated for?

☐ Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery
☐ Driving Under the Influence ☐ Hit and Run ☐ Homicide
☐ Other _____

8b. What is your present understanding of the details of the crime for which you are providing treatment?

9. If this victimization was not within the last 6 months, please describe the event(s) that brought the client into treatment at this time and describe how the event(s) are related to the qualifying crime.

If your client became the primary caretaker of a minor direct victim after the qualifying crime and who did not have a previous relationship to the direct victim, please skip to question # 18.

10. Please evaluate this client with respect to the criteria in the current **Diagnostic and Statistical Manual of Mental Disorders (DSM).** Evaluate on all 5 axes. Please complete this section as fully and accurately as possible.

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

11. **If this client is six years of age or older**, please evaluate him or her on the Social and Occupational Functioning Assessment (SOFA) scale that is discussed in the current DSM. (Note: Rate the relational unit in which he or she resided at the time of this report). Score:_____. ☐ N/A - Client is under 6 years of age.

12. Please evaluate the client on the Global Assessment of Relational Functioning (GARF) scale that is discussed in the current DSM. (Note: Rate the relational unit in which this client resided at the time of this report.) Score: _____.

13. Please describe any factor(s) not already noted which you believe may have a significant impact on the course of your treatment of this client:

14 **. TREATMENT PLAN**

What symptoms/behaviors will be the focus of your treatment? Please list the symptoms/behaviors below and the intervention you plan to use to address each symptom/behavior listed.

Symptom/Behavior:	Intervention:
Symptom/Behavior:	Intervention:
Symptom/Behavior:	Intervention:
Symptom/Behavior:	Intervention:

15. How will progress be measured?

16. Has this treatment plan been discussed with and consented to by the client or the client's caretaker?
☐ Yes ☐ No

17. If this client is a minor, is there a primary caretaker(s) involved in the treatment? ☐ Yes ☐ No ☐ Not a minor
If yes, please explain the nature and extent of involvement?

Please complete questions 18 through 21 only if your client became the primary caretaker of a minor direct victim after the qualifying crime and did not have a previous relationship to the direct victim. Please note that, pursuant to Government Code, section 13957(a)(2)(B)(i), all treatment for these clients must be necessary for the direct victim's recovery before reimbursement may be considered.

18. Please describe why the treatment you are proposing is necessary for the recovery of the *direct victim(s).*

19. What symptoms/behaviors exhibited by the *direct victim* will be the focus of your treatment for your client?

20. What intervention(s) do you plan to address for each of the symptoms/behaviors described above?

21. Please describe the arrangements you have made in coordinating this treatment with the treatment being provided to the *direct victim*:

DECLARATION

CLIENT NAME: _____ APPLICATION NUMBER: _____

If the victim's offender is convicted, the Victim Compensation Program will request the criminal court to order the offender to pay restitution to reimburse the Victim Compensation Program for any expenses the Victim Compensation Program has paid for this crime. As a treating therapist you must be prepared to testify in a restitution hearing that the mental health counseling services you provided were necessary as a direct result of the crime at the percentage indicated below.
Please Note: ***The Victim Compensation Program can only pay for the percentage of treatment that is necessary as a direct result of the crime for which the application was filed.***

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

☐	0 %	☐	75%
☐	25%	☐	100%
☐	50%	☐	Other: _____%

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Victim Compensation Program or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under *Government Code section 12651* for filing a false claim with the State of California and/or guilty of a misdemeanor or felony *pursuant to Penal Code section 72*, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

I understand that mental health counseling beyond a client's session limit must be approved in advance and that if treatment is provided without the required approval, the Victim Compensation Program may not reimburse those expenses.

IMPORTANT – YOU MUST PROVIDE THE REQUIRED SIGNATURE(S) BELOW

Treating Therapist:

Name: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

If Registered Intern:

Supervising Therapist's Name: _____
(Please Print Clearly)

Signature: _____ Date: _____

Telephone Number: _____

Tax Identification Number of person or organization in whose name payment is to be made:

_____

If you would like to be contacted by email when possible, please enter your email address below (optional).

_____